The American Psychiatric Association Presents

A Vision for the Mental Health System

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American Psychiatric Association

Presents

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A 15-year-old girl with severe substance abuse, depression, and suicidal intent and plan remains stuck in an emergency room for more than four days because there are no psychiatric beds available within a 250-mile radius. A 40-year-old man with a 20-year history of paranoid schizophrenia is picked up by the police for vagrancy and shoplifting shortly after his discharge from a psychiatric unit of a general hospital, and is discovered hallucinating in his jail cell after making a suicide attempt. A 35-year-old unemployed stock broker with symptoms of severe panic disorder is unable to find a psychiatrist for a timely appointment after calling ten physicians on a panel provided by his managed care company. A patient with schizoaffective disorder has had five different inpatient and outpatient psychiatrists in the space of six months having been re-hospitalized three times and discharged to day and outpatient programs. An 80-year-old patient with moderate dementia and major depression is hospitalized after the community mental health center that provided home visits and psychiatric care is forced to cut back community outreach services.

"America's mental health service delivery system is in shambles." [1] At a time when treatment for psychiatric illness has never been more effective, access to that care is fragmented, discontinuous, sporadic, and often totally unavailable. The numbers of individuals with serious and persistent mental illness (SPMI) who are incarcerated or homeless and without support have reached epidemic proportions.[2] The shortage of psychiatric hospital beds is endemic in many states across the country, and growing gridlock in our emergency rooms extends for days at a time as adults and children wait for an available psychiatric bed.[3] Outpatients struggle with a list of approved psychiatric physicians from their managed care company, unable to find one who can make a timely appointment for an initial visit.[4] In underserved and rural areas, it is often difficult for patients and families to find a clinician who can diagnose and treat. There is a nearly total disconnect between substance abuse and mental health treatment, and many disincentives for integration of psychiatric and medical services at the primary care level.[5] What should the mental health system look like in 21st century America? What are the values that guide advocacy for a genuine, responsive mental health system?

The Right to Quality Psychiatric Care

Every American with significant psychiatric symptoms should have access to an expert evaluation leading to *accurate and comprehensive diagnosis* which results in an *individualized treatment plan that is delivered at the right time and place, in the right amount, and with appropriate supports such as adequate housing, rehabilitation, and case management when needed. Care should be based on continuous healing relationships and engagement with the*

whole person rather than a narrow, symptom-focused perspective. Timely access to care and *continuity of care* remain today cornerstones for quality even as a *continuum of services* is built that encourages maximum independence and quality of life for psychiatric patients.

The *physician-patient relationship* is central to any reform of the health system. It encompasses confidentiality, continuity of care, and the ethical responsibility always to put the patient's needs first. Physicians need adequate time to complete an individualized evaluation of the patient that includes not only the medical and psychiatric clinical status but also the patient's personality, social and family circumstances, and immediate environmental needs. Such comprehensive evaluations may require obtaining information from other medical, mental health, and social service specialties to integrate with the psychiatric evaluation.

Confidentiality in the doctor-patient relationship and privacy are cornerstones of psychiatric values and a special challenge in today's complex communications environment utilizing always-changing medical information technology. Patients will not come for treatment if their information is shared without their explicit permission.

Psychiatric illness encompasses a broad spectrum of problems from the depressed child to a relapsed alcoholic to the anxious executive and the chronically ill patient with schizophrenia. Accordingly, proper care entails a wide range of options that can be tailored to individual needs. *Multiple modes of access* must be maintained in the system of the future. *Evidence-based care* must be encouraged and utilized. Proactive *diversion from jails, prisons, and the streets* must be planned and implemented. Acute inpatient care for most of those who need it and long-term residential care for a few must be available now and in the future. *Homelessness* among the mentally ill must be addressed and eliminated. Comprehensive and integrated approaches with multiple medical and mental health providers and social service agencies must join together to overcome the current fragmented, wasteful, and ineffective non-system we have today.

The Olmstead decision of the U.S. Supreme Court asserts that mental disabilities are true disabilities and establishes that institutionalization of persons with mental disabilities can constitute discrimination when that person could be reasonably accommodated in an integrated community setting. All persons with disabling mental illnesses should be able to receive individualized psychiatric evaluation and treatment that allows maximum independence and productivity.

The fragmentation and disintegration of care are the real challenges in developing a genuine mental health system. A genuine mental health system is more than the asylum movement of the 19th century or the community mental health centers in the mid-20th century or the more recent debacle of excessive utilization management that has forced patients prematurely out of hospital settings, split psychotherapy from psychopharmacology, separated primary care and specialty psychiatry, and focused on cost savings to the detriment of the physician-patient relationship.

Payments and Costs

Payment for care should be nondiscriminatory and *cost containment principles such as utilization review should be identically applied to health and mental health*, that is, in a nondiscriminatory fashion. *The budget for dealing with psychiatric illness should be interpreted*

broadly to account for all the cost shifts that occur today from mental health to the criminal justice, general health, welfare, and disability systems across the political landscape.

It is an unrealistic expectation that any changes in the funding of the mental health system should be "budget neutral." Reduced funding for treatment in the public and private systems has created the current crisis in which we find ourselves.

Many of our most resource-intensive patients have moved to other arenas of social policy, and a true budget must consider the cost offsets in general health, welfare, and criminal justice that would be remedied by devoting more funds to accessibility of quality diagnosis and treatment. Employers especially need to appreciate that failure to fund mental health care leads to costs in other dimensions, including lower productivity, higher absenteeism, and loss of valuable employees. Our advocacy must extend to dramatically improving the funding for treatments of psychiatric illness in both government-financed and employer-financed health systems. Employer-based private insurance mental health expenditures have dropped from 7.2 percent of total health spending in 1992 to 5.1 percent of total spending in 1999.[6]

A System for the Seriously and Persistently Mentally Ill[*]

For those with serious and persistent mental illness (SPMI), what we need in a genuine mental health system is:

- < Full access to treatment, rehabilitation, and support services in a coordinated and comprehensive system of care that is culturally competent;
- < Continuity of care;
- < Treatment that meets standards of care that are supported by best practice research;
- < Pharmacological intervention based primarily on efficacy and total cost rather than short-term costs;
- < Treatment in the least restrictive setting that is consistent with both safety and reasonable expectations of benefit;
- < Financial support adequate to meet basic human needs;
- < Safe, supportive housing with the ultimate goal being housing as independent as possible;
- < Daily activity that is meaningful, productive, and life-enhancing;
- < Social opportunities and collegiality within a community;
- < Support services that assist attaining this quality of life.

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[*]   This section derives from an APA Assembly Task Force on SPMI which reported in November 2002 and was approved by the APA Board of Trustees in March 2003.

Mandatory Treatment

What about the SPMI patients who deny that they are ill, are hospitalized multiple times, and are potentially dangerous if not in treatment? Psychiatric care differs from general medical treatment due to the fact that psychiatrists treat some patients who are not able to appreciate that they need treatment. With the twin movements of de-institutionalization and managed care, there is less available funding for inpatient treatment. Involuntary hospitalizations occur in every state based on criteria that emphasize dangerous to self or others or grave disability. Sadly, involuntary hospitalization is often not available for patients who are not dangerous but who urgently need comprehensive evaluation and intensive treatment that is not possible outside a hospital. After patients are initially stabilized, they are often discharged and some are repeatedly noncompliant with outpatient care. Mandatory outpatient treatment is a useful tool and a preventive intervention for those who may not presently meet criteria for inpatient commitment but need treatment to prevent relapse or deterioration that would predictably and rapidly lead to their qualifying for admission. More than 40 states and the District of Columbia have commitment statutes permitting mandatory outpatient treatment, and studies of such treatment have been linked to improved patient outcomes such as reduced hospitalization rates and decreased violent behavior. Any humane and comprehensive quality mental health treatment system must make provision for both inpatient and outpatient involuntary treatment for those severely and/or persistently mentally ill who can benefit from such approaches

A System of Care for Children, Adolescents, and Families

The crisis of access to child and adolescent mental health services is particularly acute. According to the Surgeon General's Report on Mental Health, one child in five suffers from a psychiatric or substance abuse disorder.[8] However, research consistently demonstrates that the majority of these children are not receiving effective and appropriate treatment.

Children and adolescents with psychiatric illnesses have certain unique needs which must be addressed in the design, development, and implementation of any comprehensive system of care. Child and adolescent mental health services should be community-based and family-centered, with a focus on existing strengths and resources. Emphasis should also be placed on:

< Identifying children with emotional and behavioral problems as early as possible;
< Ensuring access to a comprehensive continuum of clinical services including emergency/crisis, outpatient, inpatient, and intermediate-level programs (e.g., day hospital, respite, residential treatment, and home-based services), with sufficient time to evaluate fully and address the clinical state, family and social situation, emotional and cognitive development, and personality of the child;
< Facilitating access to services through school-based and primary care settings;
< Improving coordination between mental health, substance abuse, education, social services, and juvenile justice at the local, state, and federal levels.

We must also achieve an adequate and appropriate number of well-trained mental health professionals to evaluate and treat children and adolescents with psychiatric illnesses.

To do so, our training programs must expand and prioritize recruitment into the seriously underserved subspecialty of child and adolescent psychiatry. Additionally, enhanced funding for research into the etiology, treatment, and prevention of child and adolescent psychiatric disorders must be an urgent priority.

The good news is that we can help most children and adolescents who suffer from psychiatric disorders. The real tragedy is that so many young people still do not receive the comprehensive treatment they need and deserve.

Access to Care for the Older Adult and for Ethnic and Racial Minorities

Mental illness in older adults is under-diagnosed and under-treated. There are considerable barriers for the elderly in accessing psychiatric treatment. As the population ages, it has been estimated in the Surgeon General's Report that the number of adults over age 65 with major psychiatric illness will more than double from 7 to 15 million individuals by 2020.[8] Medicare continues to discriminate against treatment for mental illness by requiring a 50 percent co-pay for psychiatrists in contrast to a 20 percent co-pay for other physicians. Parity for mental health care under Medicare is a long overdue and urgent priority.

Furthermore, many other individuals who need treatment do not receive it. This is especially true in rural areas and for ethnic and racial minority groups. The Surgeon General's Supplemental Report[9] underscored these disparities in access to care for ethnic and racial minorities as compared to the general population. The report found that racial and ethnic minorities bear a greater burden from unmet mental health needs and thus suffer a greater loss to their overall health and productivity. Most minority groups are less likely than whites to use services, and they receive poorer quality mental health care despite having similar community rates of mental disorders. In addition, the IOM report[10] released in March 2002 also highlights the racial disparities that result in decreased access and increased disability burden. Further, minorities are overrepresented among the nation's vulnerable, high-need groups such as homeless and incarcerated persons. These subpopulations have higher rates of mental disorders than do people living in the community. Taken together, the evidence suggests that the disability burden from unmet mental health needs is disproportionately high for racial and ethnic minorities relative to whites.

A Conceptual Foundation for the Design of a Rational Mental Health System

The Interim Report of the New Freedom Commission on Mental Health emphasizes a "recovery" approach for the treatment of the seriously mentally ill.[11] Although not incompatible with a biomedical and public health approach, the "recovery" model is based on rehabilitative and psychosocial concepts. Another approach which should be pursued is based on the biomedical and public health perspective and is a powerful and forward-looking conceptual foundation for designing a rational mental health system is the "global burden of disease model" jointly developed by the World Health Organization and the World Bank.[12] The Surgeon General's Report on Mental Health (1999) describes this model in some detail. Its major strength is a common approach across all medical, surgical, and psychiatric illnesses defined as disability adjusted life years (DALYS). This combines years of life lost (YLLs) as a result of premature death with years of life lived with disabilities (YLDs). The latter approach is calculated as the product of the prevalence of these disorders with duration of disabling symptoms and the severity of the disability. Chronic diseases with high levels of disability,

such as major depression, bipolar disorder, schizophrenia, are among the illness with high prevalence and high morbidity that contribute to years of disability. The new NIMH Director, Thomas Insel, has announced that one of the major public health goals of NIMH is to reduce YLDs associated with major depression by ten percent by the year 2010.[13]

There is clearly great disparity between the funding of treatment for psychiatric care and medical/surgical illnesses. In the U.S., the burden for disease accounted for by mental disorders is 20 percent, whereas only 5-7 percent of all health expenditures are directed toward treatment of these disorders.[14] Based on a relatively high prevalence rate and level of associated disability, major depression is the leading cause of disability in the United States for all disorders. Since we now have excellent epidemiological information on the prevalence rates of all mental disorders in the United States, there is a quantitative basis for determining DALYS associated with specific disorders. It is clear that additional funds are warranted to bring funding more in line with the 20 percent of DALYS associated with mental disorders. This approach lends itself to the monitoring of prevalence rates, the treatment costs of these disorders, and the cost benefit in reducing DALYS associated the allocation of resources.[15] This is an evidence-based approach to reformulate budgetary priorities at a time of scarcity to provide a rationale for increased funding for treatment of mental disorders.[16]

Introduction of nondiscriminatory insurance coverage ("parity") for mental disorders is one significant step in making those additional resources available. Many individuals with disabling anxiety and mood disorders predominantly belong to insured population groups, and any reduction of YLDs associated with depression, for example, will come as the result of improved access to appropriate treatment. Increased ability to access insurance benefits that provide reasonable coverage for mental illness (including private, Medicaid, and Medicare) would increase patient choice of mental health provider and reduce the burden on the public system. Reductions in state funding have resulted in a massive cost shift of care to the criminal justice system; incarceration is a costly, ineffective, and inhumane method for dealing with individuals with severe mental disorders. Reallocation of criminal justice funds to treatment for mental disorders would address the source of the problem by providing an evidence-based strategy to reduce DALYs associated with low prevalence severe disorders and all other disorders treated in the public system. Such a comprehensive health and human service reform would result in allocating resources more in line with the 20 percent of DALYS associated with mental disorders.

Progress in Opportunities for Effective Treatment

Within the last quarter century, a number of significant if not revolutionary medical treatments and psychosocial techniques have been developed. These have demonstrated good outcomes, dramatically enhancing treatment success for virtually every psychiatric illness. We have become more reliable in our diagnostic abilities through the scientific advancement of the *Diagnostic and Statistical Manual* (DSM), now in its fourth edition, supported by the American Psychiatric Association.[17] Our emerging science base and sophistication regarding specific treatments for specific conditions, including a new generation of effective medications and psychosocial treatments, augment recovery and raise hopes of "cure." Electronic technology for recording and communicating medical information, with stringent safeguards to protect privacy (particularly sensitive psychotherapy material), can facilitate continuity of care when multiple clinicians and facilities must be involved in the care of

a patient. Adopting evidence-based approaches in the emerging trend among psychiatrists and other clinicians provides a very compelling rationale for expanding the funding of treatments outlined above. Persons with psychiatric illness throughout our country should have the opportunity to access expert clinicians with the knowledge and ability to provide effective treatment.

In the Institute of Medicine's report, *Crossing the Quality Chasm: A New Health System for the 21st Century*[18] six general principles of health care services are elucidated that have strong application in the design of a mental health system. These services must be:

< safe – avoiding injuries to patients from care that is intended to help them;
< effective – providing services based on scientific knowledge to all who can benefit and refraining from providing services to those not likely to benefit. This must be applied with caution to avoid depriving very seriously ill persons of all hope of improvement or recovery of function. New treatments have brought great benefit to many SPMI who would previously have been considered beyond any effective treatment.
< patient-centered – providing care that is respectful of and responsive to individual patient preferences, needs, and values;
< timely – reducing wait and sometimes harmful delays for both those who receive and those who give care;
< efficient – avoiding waste; and
< equitable – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

This report also emphasized that care should be based "on a continuous healing relationship." This is probably the most critical problem facing the mental health system today. The current system does not provide this continuing healing relationship for many, if not most, of those who need care and treatment.

Who is Responsible?

Today, there is an increasing blurring of the boundaries between public and private delivery of services. Much of the care delivered in private office and hospital settings is financed by the public sector (Medicare and Medicaid as well as state and county mental health funds), and the public sector remains a critical component in the design of a mental health system of the future. *State government* must be the ultimate locus of accountability as it is responsible for those patients who fall through the cracks of our non-system. *The federal government* must lead the way towards non-discriminatory mental health care by eliminating those discriminatory aspects in Medicare such as the 50 percent co-pay and the exclusion of Institutions for Mental Diseases (IMDs) from full Medicare coverage. We need national legislation to require all employer-based insurance to include mental health and substance abuse in parity with other medical conditions.

Employers are presently responsible for the funding of care for the workforce and should embrace early intervention, expert diagnosis and treatment, and non-discriminatory funding of care. Our fragmented system of health care has been decimated further by the managed care marketplace that carves out mental health care from general health care, discourages integrated psychotherapy and medication management by psychiatrists, denies

payment for long-term treatment of severe illness in favor of less effective episodic acute care, and disrupts continuity of physician-patient relationships as employers change from one MCO to another and then yet another. Employers can play a major role in demanding an end to these detrimental practices, and this is consistent with their own economic self-interest.

In summary, APA advocates the following:

Twelve Principles for a Vision for Our Nation's Mental Health System

1. Every American with psychiatric symptoms has the *right* to a comprehensive *evaluation* and an accurate *diagnosis* which leads to an appropriate, individualized plan of treatment.

2. Mental health care should be *patient and family centered*, community based, culturally sensitive, and easily accessible without discriminatory administrative or financial barriers or obstacles.

3. Mental health care should be *readily available* for patients of all ages, with particular attention to the specialized needs of children, adolescents, and the elderly. Unmet needs of ethnic and racial minorities require urgent attention.

4. *Access* to mental health care should be provided *across numerous settings*, including the workplace, schools, and correctional facilities. An emphasis should also be placed on the early recognition and treatment of mental illness.

5. Patients deserve to be treated with *dignity and respect*. When they are clinically able, they are entitled to choose their physician or community-based agency and to make decisions regarding their care. When they are incapable to do so, they should receive the treatment they need and when able, they should choose future care.

6. Patients deserve to receive care in the *least restrictive setting possible* that encourages maximum independence with access to a full continuum of clinical services, including emergency/crisis, acute inpatient, outpatient, intermediate level, and long-term residential programs.

7. Since mental illness and substance abuse occur together so frequently, mental health care should be fully *integrated* with the *treatment of substance abuse* disorders and with primary care and other general medical services.

8. Support must expand for *research* into the etiology and prevention of mental illness and into the ongoing development of safe and effective treatment interventions.

9. Efforts must be intensified to combat and *overcome the stigma* historically associated with mental illness through enhanced public understanding and awareness.

10. *Health benefits*, access to effective services, and utilization management must be the *same* for people with *mental* illness as for *other medical* illnesses, preferably funded by integrated financing systems. Although states are the ultimate locus of responsibility for the public safety net, the federal government and the private sector employers must also

support an increased investment in the mental health of Americans.

11. *Funding* for care should be *commensurate with the level of disability* caused by a psychiatric illness. Disability occurs both in the severely and persistently mentally ill and in patients with other unforeseen psychiatric conditions who suffer despite having previously been productive and functional.
12. *More resources* should be devoted to *treatment* and to *training* an adequate supply of psychiatrists, *especially child* psychiatrists, to meet the current and future needs of the population.

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